Nebraska Department of Health and Human Services

Nebraska Department of Health and Human Services, Division of Public Health
LICENSURE – CHILDREN'S SERVICES LICENSING
Health Information Report

For Family Child Care Homes I and II, this Health Information Report must be current within six (6) months from the date of the health assessment.

SECTION A:
THIS SECTION TO BE COMPLETED BY THE APPLICANT/PROVIDER. ALL BLANKS MUST BE COMPLETED.

Name				Birthdate
Street Address	City	State	Zip Code	Telephone No.

If applicable, indicate name and address of facility for whom you work:

Name of Facility			
Street Address	City	State	Zip Code

List all **prescription** medications you are currently taking: (List **NONE** if you are not taking any prescription medications)

Signature of applicant/provider **SIGN HERE**	Date

SECTION B:
TO BE COMPLETED BY HEALTH PROFESSIONAL

Blood Pressure

Urinalysis
Albumin_____ Sugar_____

Has this individual been treated or currently being treated for the following:

Substance Abuse or Dependency: ☐ Yes ☐ No ☐ Unknown
If yes, give date:_____

Alcohol Abuse or Dependency: ☐ Yes ☐ No ☐ Unknown
If yes, give date:_____

Mental Illness: ☐ Yes ☐ No ☐ Unknown
If yes, give date:_____

Hypertension/ High Blood Pressure: ☐ Yes ☐ No ☐ Unknown
If yes, give date:_____

A Communicable Disease: ☐ Yes ☐ No ☐ Unknown
If yes, give date:_____

Another condition that may affect his/her ability to care for children: ☐ Yes ☐ No ☐ Unknown
If yes, give date:_____

If the answer is "No" to all of the questions in Section B, and the individual is not on medication, and the individual's blood pressure is within normal range, and the individual's urinalysis is negative for albumin and sugar, a Registered Nurse may sign this form to indicate that the individual does not have a known health condition that could negatively affect the individual's ability to care for children.

Signature of Registered Nurse **SIGN HERE**		Date	
Printed Name		Telephone Number	
Street Address	City	State	Zip Code

If the answer is "Yes" to any of the questions in Section B, or the individual is on medication, or the individual's blood pressure is not within normal range, or the individual's urinalysis is positive for albumin or sugar, a Physician, Physician Assistant, or Nurse Practitioner must assess and explain the impact of the individual's health condition on the ability to care for children and must sign this form.

Signature of Physician, Physician Assistant, or APRN-NP		Date	
Printed Name		Telephone Number	
Street Address	City	State	Zip Code